U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 September 2006

CASE NO.: 2004-BLA-6046

In the Matter of:

J.C.,
Claimant

v.

OSBORNE BROTHERS, INC.,
Employer

and

WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances

Joseph E. Wolfe, Esq.
For the Claimant

William S. Mattingly, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (Act). The Act and implementing regulations, 20 C.F.R. Parts 718 and 725 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by

pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

ISSUES

1. Whether Claimant has pneumoconiosis,
2. Whether Claimant's pneumoconiosis arose from coal mine employment,
3. Whether Claimant is totally disabled, and,
4. Whether Claimant's total disability is caused by pneumoconiosis.

The findings of fact and conclusions of law that follow are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law.

FINDINGS OF FACT

Procedural History

Claimant filed a claim for benefits on December 17, 1992. This claim was denied by the District Direct on May 28, 1993. Claimant did not take any further action on this application. (DX-1).[1] Claimant filed the present claim, his second application, on May 1, 2003. (DX-3). The District Director issued his Proposed Decision and Order – Denying Benefits on December 17, 2003. (DX-28). The District Director determined that Claimant was unable to establish that he has pneumoconiosis and that he is totally disabled by pneumoconiosis. On January 6, 2004, Claimant requested a hearing before an administrative law judge. (DX-29). This matter was transferred to the Office of Administrative Law Judges on March 25, 2004. (DX-33). A hearing was scheduled for April 26, 2006. On April 24, 2006, I issued an Order granting Claimant's request for a decision on the record and cancelling the hearing.

The record contains 33 exhibits from the District Director, one exhibit from Claimant, and eight exhibits from Employer. I hereby admit Director's Exhibits 1-33, Claimant's Exhibit 1, and Employer's Exhibit 1-8. I received Claimant's closing argument on June 22, 2006 and Employer's closing argument on June 23, 2006.

Length of Coal Mine Employment

The District Director found 31 years of coal mine employment. (DX-28). I find the Social Security records are consistent with this finding. (DX-7). Thus, I find that Claimant was a coal miner for 31 years.

[1] The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's/Carrier's exhibit, and CX = Claimant's exhibit.

Responsible Operator

The records reflect that Osborne Brothers, Inc. was the last coal mine operator to employ Claimant for more than one year. Thus, I find that Osborne Brothers, Inc. is properly named the responsible operator.

Date of Filing

Claimant has one dependent for purposes of augmentation. Records show that Claimant is married. (DX-8).

Subsequent Claim

Because this is Claimant's second claim and thus a subsequent claim, Claimant must prove that one of the applicable conditions of entitlement has changed since the denial of his prior claim. 20 C.F.R. § 725.309. Subsequent claims must be denied on the same grounds as the previously denied claim unless the claimant can demonstrate an element of entitlement previously adjudicated against him. I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

In this case, Claimant's most recent claim was denied on May 28, 1993 because Claimant failed to establish that he had pneumoconiosis, that his pneumoconiosis arose from his coal mine employment, and that he was totally disabled due to pneumoconiosis.[2] (DX-1). Because the prior claim was denied on the basis that the Claimant failed to establish these three elements of entitlement, I will initially determine whether the evidence submitted since 1993 now establishes any of these elements of entitlement. If one of these elements is established, then I will weigh all record evidence, including evidence submitted in his prior claim, to determine if the Claimant has established all elements on the merits. Otherwise, the subsequent claim must be denied.

[2] The District Director found that total disability was established because Claimant's blood gas test met the necessary standards of total disability. However, he stated that the evidence did not show that the impairment was caused by black lung disease. (DX-1).

New Medical Evidence

Chest X-rays

Exhibit	X-ray Date	X-ray Read	Physician/ Qualifications	Interpretation
DX-11*	6/5/01	6/5/01	Shahan	No significant abnormality.
DX-11*	11/20/02	11/20/02	Miller	No radiographic evidence of acute disease.
DX-11*	2/26/03	2/26/03	Pathak	No acute pulmonary pathology.
DX-16	6/2/03	6/2/03	Forehand / B	Film completely negative.
DX-17	6/2/03	6/16/03	Name illegible / BCR, B	Quality reading only – quality 2.
EX-1	2/24/04	3/8/04	Castle / B	Quality 1, no parenchymal or pleural abnormalities consistent with pneumoconiosis.
CX-1	5/18/05	5/20/05	Rasmussen / B	Quality 2, s/s, all lung zones, profusion 1/1, pleural thickening on the right and left diaphragm and pleural calcification on right diaphragm.
EX-7	5/18/05	5/3/06	Spitz / BCR, B	Quality 2, no parenchymal or pleural abnormalities consistent with pneumoconiosis. Linear strand in right lower lung and post-surgical changes. No coal workers' pneumoconiosis.

* Medical record - x-ray not read for diagnosis of pneumoconiosis

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV_1	FVC	MVV	FEV_1/FVC	Qualifying?
DX-15	6/2/03	68"	74	2.06	3.42	64	60%	No
EX-1	2/24/04	69"	74	1.89	2.98	72	64%	No
				2.30*	3.39*	----	68%*	No
CX-1	5/18/05	67"	76	1.92	3.46	----	61%	No
				2.09*	3.41*	----	61%*	No

* Post-bronchodilator value

A report of a pulmonary function study performed on March 3, 2003 is contained within the medical records of Director's Exhibit 11. There are no values provided with the report. Dr. Patel noted that the spirometry revealed a mild reduction in flow vital capacity with a mild reduction of flow rate and a mild reduction in FEV1. He noted the MVV is significantly reduced and there was no significant response to bronchodilators. He also found a moderately reduced DLCO. He concluded that these findings were consistent with mild COPD but that he could not rule out any restrictive lung disorders without a complete lung volumes. (DX-11).

Blood Gas Studies

Exhibit	Date	PCO2	PO2	Qualifying?
DX-13[3]	6/2/03	34 32*	62 63*	Yes Yes
EX-1	2/24/04	38.4	78	No
CX-1	5/18/05	34 31*	66 77*	Yes No

* Post-exercise result

Physician Opinion Evidence

Dr. J. Randolph Forehand

Dr. Forehand conducted an examination of Claimant on June 2, 2003 on behalf of the Department of Labor. He noted that Claimant worked for 33 ½ years in coal mine employment with 15 years underground. He recorded Claimant's medical history of frequent colds, attacks of wheezing, arthritis, and high blood pressure. He also recorded a diagnosis of silicosis in the 1980's, a loss of a finger in a mine accident, and recent knee surgery. He recorded Claimant's smoking history as being 2 packs per day from 1958 through 1983.

He noted Claimant's complaints of daily gold phlegm, dyspnea with exertional activity, and cough. He noted his clinical findings of a clear chest x-ray, a mildly obstructive ventilatory pattern, and arterial hypoxemia. Dr. Forehand diagnosed Claimant with chronic bronchitis with an etiology of cigarette smoking. He concluded, "Significant respiratory impairment is present. Insufficient residual ventilatory and oxygen transfer capacity remains to continue in last coal mine job. Unable to work totally and permanently disabled." He further concluded that Claimant's chronic bronchitis is the sole factor contributing to his respiratory impairment. (DX-12).

Dr. James R. Castle

Dr. Castle conducted an examination of Claimant on February 24, 2004 and prepared a report dated March 26, 2004. Dr. Castle is Board-certified in internal medicine and pulmonary disease and is a B-reader. (EX-2). Dr. Castle recorded Claimant's complaints of difficulty with shortness of breath since before 1991, only able to walk about 50 or 60 feet without stopping because of shortness of breath, climbing one flight of stairs before stopping and resting, and running out of breath while taking out the garbage. He also noted Claimant had an occasional dry cough, without sputum, and some wheezing. He recorded Claimant's smoking history of one pack a day starting as a teenager and stopping within the last 30 to 40 years. He further recorded Claimant's coal mine employment history as 31 ¾ years with 20 years underground and the last ten years working as a mechanic out of the central shop.

[3] Dr. John A. Michos found this test to be technically acceptable. (DX-14).

On examination, Dr. Castle noted that Claimant's chest was obese, he had normal tactile fremitus and normal percussion note, breath sounds were equal throughout, and no rhonchi, rales, crackles, or crepitations were heard. Dr. Castle did hear a rare expiratory wheeze. He recorded his clinical findings as follows: the chest x-ray showed no parenchymal abnormalities consistent with pneumoconiosis; the pulmonary function studies showed evidence of mild reversible airway obstruction without restriction or diffusion abnormality; and the resting arterial blood gas study was normal and no exercise testing was done because of an abnormal electrocardiogram. Based on his examination, he concluded that there was no evidence of coal workers' pneumoconiosis but that Claimant did have a mild, reversible airway obstruction most likely secondary to asthma.

Dr. Castle also reviewed several medical records including Dr. Forehand's examination. Based on this review, Dr. Castle reiterated his opinion that Claimant did not have coal workers' pneumoconiosis. Using the smoking history obtained by Dr. Forehand, Dr. Castle noted that a 50 pack-year history was sufficient enough to have caused Claimant to develop chronic obstructive pulmonary disease. Dr. Castle concluded that Claimant was not permanently and totally disabled as a result of coal workers' pneumoconiosis but that it was possible that Claimant was permanently and totally disabled as a result of bronchial asthma. He opined that from a purely pulmonary functional point of view, Claimant retained the respiratory capacity to return to his previous coal mining employment duties. Finally, he stated that even if Claimant were found to have radiographic evidence of coal workers' pneumoconiosis, his opinion regarding the lack of disability due to this process would not change. (EX-1).

Dr. Castle provided deposition testimony on April 10, 2006. Dr. Castle acknowledged that obese people can experience symptoms of breathlessness with exertion and with such activities as bending over, putting on shoes, and things that compress the abdomen. He also reiterated his findings that the x-ray showed no abnormalities consistent with pneumoconiosis; that the studies showed a mild reversible airway obstruction without restriction or diffusion abnormality; and a significant degree of reversibility in his impairment with bronchodilators. Dr. Castle opined that Claimant's mild airway obstruction was primarily a result of bronchial asthma. Dr. Castle also opined that Claimant's mild hypoxemia at rest was more likely due to obesity and possibly asthma because it improved with exercise. Dr. Castle concluded that if Claimant's asthma were treated properly, then Claimant's lung function would be good enough for Claimant to do his work. (EX-6).

Dr. D.L. Rasmussen

Dr. Rasmussen conducted an examination of Claimant and provided a report dated May 18, 2005. Dr. Rasmussen is Board-certified in internal medicine and forensic medicine and is a B-reader. He recorded that Claimant began experiencing shortness of breath with exertion 15 years ago and that it gradually was getting worse. He noted that Claimant was now limited to climbing a single flight of stairs slowly. Claimant denied chronic cough or phlegm, orthopnea, paroxysmal dyspnea, or ankle swelling. Dr. Rasmussen recorded that Claimant wheezes in cold weather and catches colds frequently. He noted Claimant's myocardial infarction in January 2005 and the coronary artery bypass graft surgery with aortic valve replacement. He noted that Claimant reported no apparent residual cardiac problems. Dr. Rasmussen recorded Claimant's

smoking history as beginning in 1955 through 1980 at a rate of one pack per day. He recorded Claimant's work history of 31 ½ years in the coal mine industry with 15 years underground. He noted that Claimant's last work as a shop mechanic required heavy lifting.

Upon exam, Dr. Rasmussen noted normal chest expansion, diaphragmatic excursions, and breath sounds with no rales, rhonchi or wheezes. He noted his clinical findings of pneumoconiosis on a chest x-ray with a s/s profusion of 1/1. He also noted a slight reversible obstructive ventilatory impairment and minimal resting hypoxia. He concluded that Claimant was not able to perform very heavy manual labor. He further concluded that Claimant had medical coal workers' pneumoconiosis and legal pneumoconiosis, which contributed significantly to his impaired lung function. He opined that Claimant's coal mine dust and possible coal mine related asbestos exposure are responsible for Claimant's pneumoconiosis. He further opined that both Claimant's cigarette smoking and coal mine dust exposure contribute to Claimant's impairment. (CX-1).

Dr. Rasmussen also provided testimony at a deposition on March 29, 2006. Upon being questioned about Claimant's weight, Dr. Rasmussen responded that his BMI would put him in the obese range and could explain some of his complaints of shortness of breath and breathlessness on exertion. Dr. Rasmussen stated that from a purely ventilatory standpoint, Claimant retained the capacity to perform his usual coal mining work requiring bursts of heavy labor. He further stated that he believed that some of Claimant's resting hypoxia was due to his obesity but that Claimant's increased physiologic dead space was one of the reasons that Dr. Rasmussen found the exercise study results to be primarily from lung disease. Dr. Rasmussen reiterated his opinion that Claimant was totally disabled from performing very heavy manual labor and that a signification portion of that is related or caused by his coal mine dust exposure. (EX-5).

Dr. Gregory J. Fino

Dr. Fino reviewed several medical records and prepared a report dated April 7, 2006. Dr. Fino is Board-certified in internal medicine and pulmonary disease, and he is a B-reader. (EX-4). He opined that Claimant had a mild respiratory impairment which is completely reversible. He opined that this would be consistent with either cigarette smoking or asthma. He noted that the respiratory impairment was a combination of airways obstruction and a slight reduction in the diffusing capacity, which did not manifest in an impairment in oxygen transfer. Dr. Fino concluded that Claimant was disabled from performing heavy labor due to a ventilatory abnormality that is completely reversible. He further concluded that the impairment was consistent with either smoking or asthma but not consistent with coal mine dust inhalation as coal mine dust-related pulmonary conditions are not reversible. Finally, Dr. Fino stated, "[Claimant] has no disability contributed to by the inhalation of coal mine dust." (EX-3).

Medical Records

There are various medical records contained in Director's Exhibits 10 and 11. Most of these records relate to other medical issues such as knee surgery, an allergic reaction to Aleve, and hearing aids. However, there are references to Claimant's pulmonary condition. A March 2,

2000 office note of Dr. Taylor records that Claimant has black lung and his lungs were emphysematous. Dr. Taylor's impression was hypertension along with bronchitis and sinusitis. A March 19, 2002 office note records that Claimants lungs were clear; he had nasal, postnasal drainage and cough; and sinusitis. A November 20, 2002 note records that Claimant's lungs were clear and that his chest had an increased AP diameter. (DX-10).

A February 13, 2002 record of Dr. Chandel recorded Claimant's medical history of heart disease, high blood pressure, GI problems, circulatory problems, stroke, and no respiratory disease. His exam produced clear respiratory sounds. X-rays were taken and findings are listed above in the x-ray section. (DX-11).

CONCLUSIONS OF LAW

Change in Condition of Entitlement

As the present claim is Claimant's second claim for benefits, and as it was filed more than one year after the denial of Claimant's prior claim, the evidence must demonstrate that one of the applicable conditions of entitlement has changed since the date the prior denial become final. This claim was filed after January 19, 2001 and is governed by the amended regulations.

This claim must be adjudicated under the regulations at 20 C.F.R. § 718 because it was filed after March 31, 1980. Under this Section, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Claimant established total disability in his prior claim so I will not assess this element unless Claimant is able to establish a change in condition in the other three elements of entitlement.

Existence of Pneumoconiosis

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)-(4). Claimant does not have any biopsy evidence and is not eligible for the presumptions.[4] In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. 20 C.F.R. § 718.202(a)(1). The x-ray interpretations of physicians who are Board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

[4] Claimant is ineligible for the § 718.304 presumption because he has not been diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is ineligible for the § 718.306 presumption because Claimant is still living.

The x-ray evidence includes three medical record evidence, one quality reading, one positive reading, and three negative readings. The three medical record x-rays were not read for the purposes of determining the presence of pneumoconiosis, and thus, I credit little weight to these readings. However, all three stated that there was no acute pathology or significant abnormality. The one positive reading was read by Dr. Rasmussen, a B-reader. The three negative readings were read by Drs. Forehand and Castle, B-readers, and Dr. Spitz, a B-reader and Board-certified radiologist. I find that Dr. Spitz, as the most-qualified to read x-rays, is entitled to the most weight. Dr. Spitz interpreted the May 18, 2005 x-ray as negative. Dr. Rasmussen's interpretation, the only positive interpretation, was that the May 18, 2005 x-ray was 1/1. I find Dr. Spitz's interpretation is entitled to the greatest weight and credit his negative reading over Dr. Rasmussen's positive reading. As such, the great weight of the evidence is negative for pneumoconiosis. Claimant has not established by a preponderance of the x-ray evidence that he suffers from pneumoconiosis.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). "Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion." 20 C.F.R. § 718.202(a)(4).

There are four medical reports rendered in this matter. Dr. Forehand examined Claimant on behalf of the Department of Labor and concluded that Claimant was totally disabled from chronic bronchitis arising from cigarette smoking and that Claimant did not have pneumoconiosis. Dr. Castle examined Claimant and opined that Claimant's pulmonary impairment was reversible after an application of bronchodilators and that he was not totally disabled and had no evidence of coal workers' pneumoconiosis. Dr. Fino did not examine Claimant but reviewed several medical records in rendering his opinion that Claimant has no disability caused from his coal mine employment but that he had a ventilatory abnormality disabling him from performing heavy labor. He opined that the ventilatory abnormality was completely reversible and was consistent with either smoking or asthma.

Dr. Rasmussen issued the sole opinion that Claimant was impaired because of his coal mine employment. He based his opinion that Claimant had clinical pneumoconiosis on the positive chest x-ray, which I credited as negative by the dually-qualified Dr. Spitz. Finding this x-ray to be negative, I find credit little weight to Dr. Rasmussen's finding of clinical pneumoconiosis. Thus, I find the great weight of the evidence does not support a finding of clinical pneumoconiosis.

Dr. Rasmussen also opined that Claimant suffered from legal pneumoconiosis. For purposes of the Act, "legal pneumoconiosis" includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(a)(3). Drs. Forehand, Castle, and Fino opined that Claimant did not have pneumoconiosis and suffered from either chronic bronchitis or asthma. All physicians found cigarette smoking to have been a contributing factor

to Claimant's impairment. Dr. Rasmussen agreed that cigarette smoking contributed but was unable to apportion the amount that cigarette smoking or coal mine dust exposure contributed. Dr. Rasmussen also acknowledged that Claimant's obesity could be contributing to his complaints of shortness of breath and his resting hypoxia. Dr. Rasmussen also included the increase physiologic dead space as a reason.

Nevertheless, I find that the weight of the opinions of Drs. Forehand, Castle, and Fino outweigh Dr. Rasmussen's conclusion. Specifically, Dr. Castle analysis was very thorough and well-reasoned in assessing the clinical findings. His opinion is well-based on the medical evidence, namely with regards to the improvement of Claimant's blood gas values on exercise and the significant reversibility of Claimant's ventilatory values. I credit great weight to his opinion that asthma and obesity caused Claimant's impairment and that if Claimant's asthma were treated properly Claimant would be able to work. Thus, I find the great weight of the evidence does not establish that Claimant suffered from legal pneumoconiosis.

Pursuant to the holding in *Island Creek Coal Co.*, I must weigh all of the evidence under 20 C.F.R. § 718.202(a) together in determining whether Claimant has established pneumoconiosis. I find that Claimant has not established the existence of pneumoconiosis through the radiological evidence. Also, I find that the medical report evidence does not support a finding of clinical or legal pneumoconiosis. I find that the great weight of the evidence does not support a finding that Claimant has pneumoconiosis.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the disease arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b).

Claimant has not established that he suffers from pneumoconiosis, and therefore Claimant cannot establish that his pneumoconiosis is caused from coal mine employment. However, Claimant has established 31 years of coal mine employment. If he were to have pneumoconiosis, he would be entitled to the presumption that it arose out of his coal mine employment.

Causation of Total Disability

The District Director did find total disability in the prior claim. (DX-1). Therefore, I do not address whether Claimant is able to establish total disability through the newly-submitted medical evidence in this claim because a finding of total disability would not establish a change in condition. However, the District Director did not find that Claimant's total disability was caused by pneumoconiosis.

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment.

Pneumoconiosis is a "substantially contributing cause" of the miner's totally disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. § 718.204(c)(1).

Claimant has not established that he suffers from pneumoconiosis. Therefore, he cannot establish that his total disability is caused by pneumoconiosis.

CONCLUSION

Claimant is unable to establish that he suffers from pneumoconiosis, that his pneumoconiosis is caused by his coal mine employment, and that he is totally disabled by pneumoconiosis. As such, he has failed to establish a change in circumstances since his prior denial. Therefore, I must deny his claim based on the grounds of his prior denial.

Attorney's Fee

The award of attorney's fees under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation services rendered to him in pursuit of the claim.

ORDER

The claim of J.C. for Black Lung benefits under the Act is hereby DENIED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

NOTICE OF PUBLIC HEARING: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). It is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.